

## Team Care Program Referral Form

To refer a beneficiary, please complete the following information and fax or mail it to:

**Fax: (802) 871-3090**

**Mail: DVHA Substance Abuse Unit  
 312 Hurricane Lane, Suite 202  
 Williston, VT 05495**

VT Medicaid, VHAP, or PC Plus Client (Patient) Information			
Name:		DOB/Age:	
Address:	City:	State:	Zip:
Telephone:		Medicaid ID or SSN if available:	

Your Information			
Name:		Date of submission:	
Address:	City:	State:	Zip:
Email:		Telephone:	
Are you a Medicaid provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID if applicable:	
Other (please explain):		Is patient aware of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Reason for Referral
<i>Please list as much detail as possible and include copies of any documents that may support referral</i>
<input type="checkbox"/> Con't. on reverse

**\*Note: There may be a delay in processing, as all referrals will be reviewed in order of priority and as workload permits. Beneficiaries may or may not meet eligibility criteria once full scope of case is known.**

**Please call (802) 871-3091/3092 for any questions about the program**

Team Care Use Only:

Date Rec'd: \_\_\_\_\_ Date Acknowledged: \_\_\_\_\_ Date Closed/Deferred: \_\_\_\_\_